STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED 01 - MAIN BUILDING 01 A. BUILDING B. WING TN4601 08/22/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 919 MEDICAL PARK DRIVE MOUNTAIN CITY CARE & REHABILITATION CE MOUNTAIN CITY, TN 37683 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) N 002 1200-8-6 No Deficiencies N 002 There were no life safety code deficiencies noted on the day of this annual licensure survey. Division of Health Care Facilities 15ranch (X6) DATE lama. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE STATE FORM G3BQ21

Division of Health Care Facilities